

## MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-008501

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

318  
FILED FEB 28 1963

1003

2060

|  |                                  |   |                                    |
|--|----------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY _____   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>                     |                                    |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>ST. LOUIS, MISSOURI</u>  |                                  | c. CITY OR TOWN <u>Webster Groves</u>   |                                    |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>BARNES HOSPITAL</u>  |                                  | d. STREET ADDRESS (If outside, give location)<br><u>305 Hillside</u>  |                                    |
| 3. NAME OF DECEASED (Type or print)<br>First <u>EDWARD</u> Middle <u>LOUIS</u> Last <u>DAHLKAMP</u>  |                                  | 4. DATE OF DEATH<br>Month <u>FEBRUARY</u> Day <u>22</u> Year <u>1963</u>  |                                    |
| 5. SEX<br><u>male</u>  | 6. COLOR OR RACE<br><u>white</u> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>3-19-96</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>supervisor</u>   |                                  | 11. BIRTHPLACE (City and state or country)<br><u>Lowell, Indiana</u>  |                                    |
| 13a. FATHER'S NAME<br><u>Henry Dahlkamp</u>  |                                  | 13b. MOTHER'S MAIDEN NAME<br><u>Mary Boehn</u>  |                                    |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service)<br><u>World War I</u>   |                                  | 17. INFORMANT<br>Address <u>Mrs. Treva Dahlkamp 305 Hillside</u>  |                                    |
| 18. CAUSE OF DEATH (Enter only one cause per line)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ADENOCARCINOMA OF CECUM WITH METASTASES</u><br>DUE TO (b) _____<br>DUE TO (c) <u>153.0</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____ |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><u>11 mos.</u>  |                                    |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>   |                                    |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)   |                                  | 22c. DATE SIGNED<br><u>2/23/63</u>  |                                    |
| 20c. TIME OF INJURY<br>Hour _____ a.m. _____ p.m.<br>Month, Day, Year _____  |                                  | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                                    |
| 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |                                  | 20f. CITY; TOWN, OR LOCATION<br><u>Kirkwood Mo.</u>   |                                    |
| 21. I attended the deceased from <u>4/26/62</u> to <u>2/22/63</u> and last saw her alive on <u>2/22/63</u><br>Death occurred at <u>3:45 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.  |                                  | 22b. ADDRESS<br><u>BARNES HOSPITAL</u>  |                                    |
| 22a. SIGNATURE (Degree or title)<br><u>E.D. Vermillion M.D.</u>  |                                  | 22c. DATE SIGNED<br><u>2/23/63</u>  |                                    |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>removal</u>  |                                  | 23b. DATE<br><u>2-25-63</u>   |                                    |
| 23c. NAME OF CEMETERY OR CREMATORY<br><u>Oak Hill Cemetery</u>   |                                  | 23d. LOCATION (City, town, or county)<br><u>Kirkwood Mo.</u>  |                                    |
| 24. FUNERAL DIRECTOR<br><u>MITTELBERG ADDRESS COLONIAL CHAPEL</u>  |                                  | 25. DATE RECD. BY LOCAL REG.<br><u>FEB 25 1963</u>  |                                    |
| 26. REGISTRAR'S SIGNATURE<br><u>Paul Smith M.D.</u>  |                                  |   |                                    |

USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

VS 300  
Rev. 4/59

DATE AMENDED

ITEM NO.

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*Harvey F. Kahle*

Licensed Embalmer No. 4596

P. O. Address St. Louis, MO.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.